

Amendments to
WEA Trust Dental Plan
A WEA Insurance Corporation Group Dental Policy



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The following amendments will take effect on January 1, 2008.

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Handwritten signature of Fred J. Evert.

Fred J. Evert, President

Handwritten signature of Michael L. Stoll.

Michael L. Stoll, Vice President

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Section 1

Policyholder's Provisions: Rights and Obligations of the Employer and the WEA Insurance Corporation

The subsection, "*Conditions of Issuance*," in Section 1 of the WEA Trust Dental Plan is replaced with the following:

Conditions of Issuance

This policy will take effect on the date, and in accordance with, the terms specified in the insurance agreement between the employer and us if the following requirements are met. If these requirements are not maintained, we may terminate this policy.

1. The employer and a bargaining agent affiliated with the Wisconsin Education Association Council have negotiated WEA Trust dental plan coverage.
2. The employer's plan that provides the benefits of this policy satisfies the nondiscrimination requirements of sections 501(c)(9) and 505(b) of the Internal Revenue Code.
3. The employer meets the minimum contribution and minimum participation requirements we have established for this policy.

We will not permit this plan to be offered in a dual choice situation with another Trust or non-Trust plan without our prior written approval.

The following two subsections are added following "*Conditions of Issuance*."

Minimum Participation Requirement

We reserve the right to nonrenew or terminate this policy, at our sole discretion, if the number of employees enrolled falls below 75% of the employees eligible for coverage. In evaluating whether enrollment has fallen below 75% of eligible employees, we will apply the following rules:

1. In calculating the number of employees enrolled in the policy, we will include employees who waive coverage because they have coverage through their spouses under a WEA Trust dental plan sponsored by the same or a different employer.
2. In calculating the total number of eligible employees, we will not include as eligible employees individuals who are covered only because they elected state continuation coverage or individuals who have completed a waiver or enrollment form identifying other qualifying coverage, unless the other coverage is another health benefit plan sponsored by this employer.
3. Before the nonrenewal or termination of this policy for failure to meet minimum participation requirements, we will notify the employer of the reason for the nonrenewal or termination, consistent with all statutory notice requirements.
4. Upon request, we will continue the group dental coverage of this policy for at least 60 days after the nonrenewal or termination date, at the premium rate applicable for that

time period, in order to give the employer an opportunity to increase the number of enrolled eligible employees so as to meet the policy's minimum participation requirement. If the employer does so, we will not nonrenew or terminate the policy.

5. We will not nonrenew or terminate the policy if the number of enrolled employees is less than the required percentage due to an employee's sickness or injury, approved leave of absence, or temporary layoff.

Minimum Employer Contribution

The employer must contribute at least 50% of the premium cost for a family plan for each full-time covered employee, or 50% of the premium cost for a single plan if that is the plan selected. For part-time covered employees, the employer must contribute at least 50% of the regular contribution for full-time employees.

Section 3 of the WEA Trust Dental Plan is replaced in its entirety with the following:

Section 3

Eligibility and Dates of Coverage of Employees and Their Dependents

This section describes the individuals who are eligible for coverage under this policy. It explains when those individuals become eligible for coverage, when their coverage begins, and when coverage ends. It also describes their rights and obligations with respect to group continuation coverage.

Note: Whenever the terms “*you*” or “*your*” appear in this section, they refer only to an employee of the employer who purchased this group dental policy. Whenever the term “*eligible class of employees*” is used, it refers to the occupational group(s) of employees specified by the employer as being eligible for coverage as part of an insured group.

The date you become eligible for coverage is subject to any applicable waiting period. The waiting period is the length of time you must be continually at work for your employer before you are eligible for coverage under this policy. The waiting period, if any, is established by your employer and is specified in the insurance agreement between your employer and us.

How to Obtain Coverage

To obtain coverage, you must provide an enrollment form to us, listing all individuals for whom you wish coverage, within 30 days of the date you become eligible. This 30-day period is an open enrollment period during which we will enroll you and your dependents, if eligible.

If we receive your enrollment form after the 30-day period, we will deny enrollment unless you and your dependents, if applicable, provide evidence of insurability that we, in our sole discretion, deem acceptable. You must provide evidence of insurability, if required, without cost to us. Read about our “Late Enrollment Procedures and Rules” later in this section.

Even if you do not wish coverage at the time you are initially eligible, you should submit an enrollment form. If you are waiving coverage because you have other dental insurance coverage, you must clearly state that fact and identify your other dental insurance coverage.

Doing so will be necessary to preserve your rights to coverage at a later date should you lose your other coverage as described under “Special Late Enrollment Circumstances,” later in this section.

Who is Eligible and When Coverage Begins

Current Active Employees

You are eligible for coverage on the date this policy takes effect if **all** of the following apply:

- You are a member of the eligible class of employees specified by your employer.
- You are engaged in the active performance of all of your regular job duties on the effective date, or would be so engaged if that date were a regularly scheduled workday.
- You have completed any waiting period specified by your employer.

Your coverage will begin on the date this policy takes effect if we receive your enrollment form within 30 days of that date.

New Employees

If you belong to the eligible class of employees specified by your employer, you are eligible for coverage on the later of the following dates:

- The date you begin the active performance of all of your regular job duties.
- The date you complete any waiting period specified by your employer.

Your coverage will begin on the date you become eligible if we receive your enrollment form within 30 days of that date.

Disabled Employees

If you are Disabled on the date this policy takes effect, you are not eligible for coverage until the date you are no longer Disabled and you:

- Resume the active, regular performance of all of your job duties as a member of the eligible class of employees; or
- Could have resumed the active, regular performance of all of your job duties if school were in session.

Your coverage will begin on the date you become eligible if we receive your enrollment form within 30 days of that date.

There is one exception: When this policy replaces another group dental policy, your coverage will begin on the effective date of this policy, even if you are Disabled, if ***all*** of the following apply:

- You were validly covered under the previous group dental policy on the day immediately preceding the effective date of this policy.
- You are otherwise eligible for coverage under this policy.
- We receive your enrollment form within 30 days of the effective date of this policy.

This is the only time that an employee who is Disabled on the date he or she would otherwise be eligible for coverage will be covered under this policy before he or she returns to the active, regular performance of all job duties.

Employees on Paid Leave of Absence

If you are on an employer-approved paid leave of absence on the date this policy takes effect and would be actively at work on that date but for that fact, you are eligible for coverage if ***all*** of the following apply:

- You belong to the eligible class of employees specified by your employer.
- Your leave is a type that is available to all employees in the eligible class (for example, paid sick or sabbatical leave).
- Both you and your employer anticipate that you will return to work at the end of your leave.
- Your employer pays the required premium.

If all of the above criteria are fulfilled, you are eligible for coverage on the date the policy becomes effective. Your coverage will begin on the policy's effective date if we receive your enrollment form within 30 days of that date. Coverage will extend for a maximum of 2 years from the date your leave began.

Employees on Unpaid Leave of Absence

If you are on an unpaid leave of absence on the date this policy takes effect, you are not eligible for coverage until you resume the active, regular performance of all of your job duties as a member of the eligible class of employees.

Your Dependents

If you are covered by this policy, the following dependents are eligible for coverage:

1. Your legal spouse.
2. Your biological child, legally adopted child, stepchild, or legal ward* who is unmarried, and:

- Under the age of 19.
- Age 19 or older and enrolled as a **full-time student** in an accredited school, college, or university, through the calendar year in which he or she reaches age 25. These dependents are covered between school terms (for example, summer months) if they complete the preceding term.

Full-time student means a dependent who is enrolled in **school** on a full-time basis as defined by the school the student attends. **School** means an accredited college or university, or a licensed or certified vocational institution or technical training institution.

- Age 19 or older and not a full-time student, but having less monthly income than the amount we establish and periodically modify as the standard for determining whether the child is primarily responsible for his or her own financial support, through the calendar year in which he or she reaches age 25.

When we determine a dependent's income, we take into consideration expected gross income, both earned and unearned, that the dependent receives from all sources, including, but not limited to, gross wages, tips, disability benefits, worker's compensation benefits, unemployment compensation benefits, SSI benefits, veteran's benefits, AFDC benefits, real estate holdings, stocks, trust funds, gifts, and injury damage awards or settlements. Expected monthly income must be less than our monthly standard in order for the dependent to remain eligible for coverage. For example, a dependent who becomes employed with expected income that exceeds the monthly standard we have established is ineligible on the first day of employment. That dependent's coverage will end on the last day of the month during which he or she became ineligible.

***Note:** To be initially eligible for coverage, your legal ward must be under the age of 18 or must be a ward who was covered by the previous employer-sponsored group dental policy that this policy replaced. In addition, you must have sole and permanent guardianship of both the individual and the individual's estate.

3. A biological child of your covered dependent child or legal ward (i.e., your grandchild), but only until your child or legal ward becomes 18 years old or marries, whichever occurs first.

Your dependents are eligible for coverage on the date your coverage takes effect. Their coverage will begin on the date your coverage takes effect if we receive your application for their coverage within the first 30 days of their eligibility.

Children Who Become Re-eligible for Coverage—If your covered dependent child becomes ineligible for coverage because he or she no longer meets the criteria to qualify as an eligible dependent, that child will lose coverage under this policy. However, the child may once more become eligible if the criteria are again met. If this happens, coverage for the re-eligible dependent child will resume on the first of the month following the event that gave rise to the re-eligibility if you have **family** coverage and notify us promptly of the child's re-eligible status.

If you have **single** coverage and want to add a dependent child who becomes re-eligible, you must change to family coverage. In addition, we must receive the application for your dependent child's coverage within 30 days of the event that gave rise to that dependent's re-eligibility. If we do not receive the application within the 30-day time limit, your dependent child will be subject to the Late Enrollment Procedures and Rules described later in this section.

Example: You have family coverage. Your 20-year-old covered dependent, Pat, stops attending college and becomes employed on November 12 with a salary that is above our monthly standard for determining whether a child is primarily responsible for his or her own financial support. Pat is ineligible for coverage on the first day of employment, November 12. Her coverage will end on the last day of the month during which her employment began, or November 30. After two years of employment, Pat, who is now 22, returns to college as a full-time student on August 23. Assuming she meets all other eligibility criteria (remains unmarried, etc.), she again becomes eligible for coverage on August 23. Pat's coverage will begin on September 1 if you notify us before September 22.

Adding Dependents Through Marriage—If you marry, you may obtain coverage for any new eligible dependents and you may change from single to family coverage if we receive the required enrollment form within 30 days after the date of your marriage. In this case, coverage for these new dependents begins on the date of your marriage. If we receive your application for their coverage after the 30-day period, their enrollment will be subject to the “Late Enrollment Procedures and Rules” described later in this section.

Newborn Child—A newborn's coverage begins at birth if you have family coverage. If you have single coverage, you must notify us of the birth and your desire to obtain family coverage within 60 days of the birth date. If we are not notified and the required premiums are not paid within 60 days of the birth date, we may refuse coverage for the newborn unless within one year of the birth date we receive all required premiums, plus interest as permitted by law, from the date of birth. If we do not receive the required premiums within one year of the birth date, you will be able to obtain coverage for the child only through the “Late Enrollment Procedures and Rules” described below.

Newly Adopted Child—A newly adopted child is eligible for coverage on the earlier of these dates:

- The date that a court makes a final order granting adoption.
- The date that the child is legally placed with you for adoption.

Coverage for the adopted child will begin on the date he or she first becomes eligible if we receive your application for the child's coverage, or written notification of the adoption, within 60 days after that date. If we do not receive application for the child's coverage within 60 days after he or she becomes eligible, you will be able to obtain coverage for the child only through the “Late Enrollment Procedures and Rules” described below.

Legal Wards—A legal ward is eligible for coverage on the date established by the court order as the date on which you began guardianship. Coverage for the legal ward will begin on the date he or she became eligible if **both** of the following apply:

- You have family coverage.
- We receive your application for the legal ward's enrollment within 30 days after he or she first became eligible.

Late Enrollment Procedures and Rules

Late Enrollments That Require Evidence of Insurability

It is important that you apply for coverage by submitting an enrollment form listing all individuals for whom you wish coverage within 30 days of becoming eligible. Enrollment applications that are submitted to us later than the 30-day limit will be denied unless they are accompanied by evidence of insurability that meets our stringent requirements. We will require evidence of insurability for each individual listed on the late enrollment form. Any costs associated with providing that evidence will be your responsibility.

If we receive application for your own coverage more than 30 days after you are initially eligible, you must provide us with evidence of your insurability that we, in our sole discretion, deem sufficient. If we approve your enrollment based on your evidence of insurability, your coverage will begin on the first day of the month following the date of our approval. If we deny your enrollment, neither you nor any of your dependents will be eligible for coverage.

If you are covered by this policy but we receive your application to enroll any dependent more than 30 days after that dependent is initially eligible, you must provide us with evidence of that dependent's insurability that we, in our sole discretion, deem sufficient. If we approve your dependent's enrollment based on the evidence of insurability, coverage for that dependent will take effect on the first day of the month following the date of our approval. If we deem the evidence of insurability to be insufficient, we will deny the enrollment.

When we make decisions about enrollment based on evidence of insurability, we rely on the accuracy and completeness of the information submitted. We monitor all claims for such individuals for two years following our approval. If, during that period, we learn that the information we relied on was incorrect, or relevant information was omitted, we may retroactively rescind coverage and deny claims. In that case, you will be responsible for repaying us for claims that we have paid.

Late Enrollments That Do Not Require Evidence of Insurability

There is a defined set of circumstances under which we will approve a late enrollment without requiring evidence of insurability. If you and your dependents were eligible for coverage but chose, within 30 days of initially becoming eligible, to waive the benefits of this policy because you were covered by another employer-sponsored group dental plan, you will again become eligible for the benefits of this policy without providing evidence of insurability when one of these involuntary events occurs:

- You or your dependent loses coverage under the other group dental plan for any reason other than having received that plan's maximum benefit or failure to pay required premiums.

Note: A change in the type of plan providing the other dental coverage does not constitute loss of coverage under that plan; for example, the other dental plan changes insurers or moves from a traditional dental plan to a preferred provider or HMO dental plan.

- You or your dependent is required to pay 100% of the cost of coverage under the other employer-sponsored dental plan.
- This policy becomes noncontributory for your employee classification; that is, the employer pays 100% of the required premium.

If you or your dependent experiences one of these involuntary events and you wish to obtain coverage under this policy, we must receive a completed proof of involuntary loss form from you within 30 days after that involuntary loss occurs. You can get a copy of this form from your employer or by calling us. If we determine that you and/or your dependents have experienced an involuntary event and are entitled to coverage under this policy, we will notify you in writing. In this case, coverage for you and/or your dependents will begin on the date of the involuntary event if **all** of the following apply:

- You had submitted an enrollment form within 30 days of your initial date of eligibility and waived the benefits of this policy for yourself and/or your eligible dependents for the express reason that you had other dental coverage.
- You and your dependents were either eligible for coverage or were covered by this policy when you initially waived the benefits of this policy.
- You and/or your dependents were continuously covered by the other group

dental plan from the time you initially waived coverage under this policy until the involuntary event occurred.

If we determine that you and/or your dependents have not experienced an involuntary event and are not eligible for coverage through this process, we will notify you of our decision. We will also explain the procedures for submitting a late enrollment form and the required evidence of insurability.

Note: These provisions regarding “Late Enrollments That Do Not Require Evidence of Insurability” do not apply to you or your dependents if you are covered under this policy’s “Coverage Continuation Option for Retired and Disabled Employees.”

Your Duty to Provide Information

If you are covered by this policy, you must provide the information we need to both accurately determine whether your dependents are eligible for coverage and to pay benefits. For example:

- ***You must let us know when one of your covered dependents is no longer eligible for coverage.*** This will enable us to process claims accurately and extend continuation coverage as required by law. Read about “Your Legal Rights to Continuation Coverage” later in this section. If you do not notify us and, as a result, we pay claims beyond the dependent’s appropriate termination date, we have the right to retroactively terminate coverage for the individual. In this case, you must repay us for all claims that we paid beyond the appropriate termination date.
- ***You must notify us when you become covered by another group health or dental plan or by Medicare.*** The state of Wisconsin has adopted rules that must be followed by all insurers who coordinate benefits. These rules specify which insurer pays first, which pays second, etc. If we pay claims in error because you have not

informed us of other insurance coverage, we have the right to recover the overpayment. See “Our Right of Review and Recoupment” in Section 8.

- ***You must respond to our requests for information.*** For example, when your dependent child nears the limiting age when he or she may no longer be eligible for coverage, we will send you a questionnaire requesting updated information about that dependent. Sometimes we may request documentation of his or her expected gross income. We will ask for this information as often as is necessary for us to determine your dependent’s continuing eligibility for coverage. You must either complete and return the questionnaire or call one of our eligibility services representatives and provide the information. Because we use this information to pay claims, we suspend claims processing until we receive the information from you.

Periodically we will send you a questionnaire asking if you or any of your dependents are covered by any other dental policy. You must either complete and return the questionnaire or call one of our dental customer service representatives and provide the information. Because we rely on this information to coordinate benefits, we suspend claims processing until we receive the requested information. If you provide inaccurate or incomplete information and we pay claims in error as a result, we have the right to recover the overpayment. See “Our Right of Review and Recoupment” in Section 8.

- ***You must provide, at your own expense, the medical and/or dental documentation we need to determine if services are covered and/or if you qualify for waiver of premium, if applicable.*** We will tell you what we need to make this determination.
- ***You must inform us when you or your covered dependent receives dental services as a result of a work-related illness or***

Injury, and you must notify us of any worker's compensation claim you make.

You must also notify us of any worker's compensation benefits you receive as a result of an award, compromise, or settlement. Because we will use this information to determine whether any benefits are owed to you under this policy, you must promptly provide us with any related information or documentation that we require. This policy excludes services that are eligible for worker's compensation benefits whether or not you apply for or receive them. If we later discover that we have paid claims for services that were necessitated by work-related Illnesses or Injuries, we have the right to recover the overpayment. See "Our Right of Review and Recoupment" in Section 8.

When Coverage Ends

Your coverage will end on the earliest of the following dates:

- The date this policy terminates for any reason.
- The end of the period for which the last premium was paid for you.
- The date on which you enter the military forces of any state or country, including the United States. This includes being called to active duty as a member of a reserve unit of the armed forces.
- The date on which you cease to be a member of the eligible class of employees specified by your employer for coverage under this policy. Examples include, but are not limited to the following:
 1. You have a change in your job duties that makes you ineligible for coverage.
 2. The number of hours you work decreases and renders you ineligible for coverage.
- The date on which your occupational group ceases to be part of the eligible class of employees specified by your employer as being part of an insured group.

- The last day of the month in which you become ineligible because of the termination of your employment, whether voluntary or involuntary.
- The date on which you fail to comply with any provision of this policy.
- The date of your death.

Coverage for any covered dependent will end on the earliest of the following dates:

- The date this policy terminates for any reason.
- The date your coverage ends for any reason.
- The end of the period for which the last premium was paid for your dependent's coverage.
- The date on which your dependent enters the military forces of any state or country, including the United States. This includes being called to active duty as a member of a reserve unit of the armed forces.
- The date your dependent child marries.
- The last day of the month in which your dependent child no longer meets the criteria to be covered as a dependent under your coverage (for example, required age, earnings, or student status).
- The date of your dependent's death.
- The last day of the month in which you die. (Note that continuation options are available to your covered dependents in this event.)

There are three exceptions:

1. ***Continuation coverage as required by federal law.*** See "Your Legal Rights to Group Continuation Coverage" below.
2. ***Continuation option for retired and Disabled employees under limited circumstances.*** See "Coverage Continuation Option for Retired and Disabled Employees" later in this section, or the "Coverage Continuation Option for

Retired and Disabled Employees” amendment in the amendment section at the back of this policy booklet if the amendment applies to your coverage. If the amendment applies to you, it will be listed on your Benefit Summary under “Optional Benefits” that apply to your coverage.

3. ***Mental retardation or physical disability of your covered child.*** If you have a covered dependent child who is both incapable of self-sustaining employment because of mental retardation or physical disability and chiefly dependent on you for support and maintenance, coverage for that child will not end solely because he or she reaches the limiting age. You may continue coverage for that child as long as that child continues to be both incapable of self-sustaining employment and chiefly dependent on you for support. In this case, you must provide us with proof of the incapacity and dependency within 31 days of the date the child reaches the limiting age, and at any time we request it during the two-year period that follows. After the two-year period, we may request proof of incapacity and dependency on an annual basis.

Your Legal Rights to Continuation Coverage

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), provides a temporary extension of coverage for ***qualified beneficiaries*** who lose coverage under an employer’s group dental plan because of specified life events, called ***qualifying events***. The terms ***qualified beneficiary*** and ***qualifying event*** are explained below. If you or your dependents lose coverage under this policy due to a ***qualifying event***, you are entitled to continue coverage if ***all*** of the following apply:

- We receive timely notification of the qualifying event.
- You elect continuation coverage within the specified time limit.

- We continue to insure the active employees in the occupational group within the eligible class of employees to which you belonged on the day before your qualifying event.
- We receive the required premiums on time.

Under these circumstances, you may continue your coverage under this policy for a specified period. This subsection summarizes your rights and obligations regarding continuing coverage under this policy.

In addition to COBRA rights, you may also have continuation rights granted by this policy upon your retirement or in the event of total disability. (See “Coverage Continuation Option for Retired and Disabled Employees,” later in this section, and “Coverage Continuation Option for Retired and Disabled Employees” found at the back of this policy booklet.) If you elect continuation coverage, your COBRA and policy-provided continuation coverage will run concurrently, not consecutively.

What is Continuation Coverage?

Continuation coverage is a temporary extension of coverage that can become available if you and/or your covered dependents would otherwise lose coverage under your employer’s group plan. Continuation coverage is the same coverage given to other covered individuals who are in your occupational group within the eligible class of employees but who have not experienced a qualifying event. Each qualified beneficiary who elects continuation coverage has the same rights and benefits under this policy as those covered individuals until his or her continuation coverage has ended.

Qualified Beneficiaries

A qualified beneficiary is an individual covered by this policy on the day before a qualifying event occurs, who will lose coverage because of that qualifying event. Qualifying events are listed below. Depending on which qualifying event occurs, you, your spouse, and/or your children, stepchildren, and legal wards may be qualified beneficiaries. An alternate recipient

under a national medical support order that we received while you were employed may also be a qualified beneficiary.

If you have a newborn child or a child placed with you for adoption while you are on continuation coverage, that child is also considered a qualified beneficiary. That child's coverage begins when the child is enrolled in this plan (see the rules for enrollment under "Newborn Child" and "Newly Adopted Child" earlier in this section) and lasts for as long as continuation coverage lasts for you and/or your other dependents. To enroll such a child, call our Eligibility Services Department.

While you are on continuation coverage, you may also obtain coverage for a spouse or dependent child who becomes eligible for coverage under the terms of this policy, but such dependents are not qualified beneficiaries. You must apply for their enrollment within 30 days of the date they first become eligible. Coverage for these dependents ends when your continuation coverage ends, and they have no continuation rights of their own.

Qualifying Events

You will become a qualified beneficiary if you lose your coverage because of either of these qualifying events:

1. The termination of your employment for reasons other than gross misconduct.
2. A reduction in the number of your work hours.

Your spouse and/or dependent children will become qualified beneficiaries if they lose coverage because of any of the following qualifying events:

1. The termination of your employment for reasons other than gross misconduct.
2. A reduction in the number of your work hours.
3. Your death.

4. Your divorce or the annulment of your marriage.

Note: If an employee cancels a spouse's coverage in anticipation of divorce or annulment, and a divorce or annulment later occurs, the divorce or annulment will be considered a qualifying event even though the ex-spouse lost coverage earlier (in advance of the divorce or annulment). If the ex-spouse notifies us within 60 days after the date of the divorce or annulment and can establish that the employee cancelled the coverage earlier in anticipation of the divorce or annulment, continuation coverage may be available for the period after the divorce or annulment.

5. Your covered child, stepchild, or legal ward ceasing to qualify as a covered dependent.

Your Obligation to Notify Us When a Qualifying Event Occurs

We will offer continuation coverage to qualified beneficiaries only after we have been timely notified that a qualifying event has occurred. Depending on the qualifying event, either you or your employer is responsible for notifying us of its occurrence.

Your employer must notify us within 30 days of the date you experience any of the following qualifying events:

- The termination of your employment for reasons other than gross misconduct.
- A reduction in your work hours that results in the loss of coverage.
- Your death.

Important: You, your dependent, or your authorized representative must notify us within 60 days of the occurrence of any of the following qualifying events:

- Your divorce or the annulment of your marriage.
- Your covered child, stepchild, or legal ward ceasing to qualify as an eligible dependent.

If you or your dependent do not provide the required notice within the 60-day period, following the “Notice Procedures” below, you and/or your dependents will lose your rights to COBRA continuation coverage.

After we receive your notice of a qualifying event, we will acknowledge it in writing within 14 days. We will send either a notice of your right to continue coverage or a letter explaining why you are not eligible to continue coverage.

Notice Procedures

You or your employer may provide any notice required by these continuation coverage provisions by calling or writing:

Eligibility Services Department
WEA Trust
P.O. Box 7338
Madison, WI 53707-7338
(608) 276-4000 Voice/TDD
(800) 279-4000 Voice/TDD

If mailed, your notice must be postmarked no later than the last day of the required notice period. If you give your notice by phone, you must call us no later than the last day of the required notice period. We will need this information when you call or write:

1. Your name and subscriber number.
2. Your employer’s name and group number, if known.
3. The specific qualifying event that is causing, or will cause, a loss of coverage.
4. The date of the qualifying event.
5. The names of all qualified beneficiaries who have lost or will lose coverage due to the qualifying event.
6. Your telephone number, address, and the addresses of any qualified beneficiaries if different from yours.

Duration of Continuation Coverage

The maximum period of continuation coverage depends on the qualifying event. You, your spouse, or dependent child may continue coverage for up to 18 months if coverage is lost because of one of the following qualifying events:

1. The termination of your employment for reasons other than gross misconduct.
2. A reduction in the number of your work hours.

Your spouse and/or dependent child may continue coverage for up to 36 months if they lose coverage because of one of the following qualifying events:

1. Your death.
2. Your divorce or the annulment of your marriage.
3. Your covered child, stepchild, or legal ward ceasing to qualify as a covered dependent.

Extension of the Period of Continuation Coverage

An 18-month period of continuation coverage can be extended under three circumstances. In all three circumstances, the extension applies only if the initial qualifying event was the termination of your employment or the reduction in your work hours.

Extension Due to a Second Qualifying Event

Spouses or dependent children who experience a second qualifying event while on continuation coverage may be eligible for up to a maximum of 36 months from the date of the original qualifying event. An event can be a second qualifying event only if it would have caused your spouse and/or dependent child to lose coverage had the first qualifying event not occurred. The extension is available if the second qualifying event is one of these:

1. Your death.
2. Your divorce or the annulment of your marriage.

3. Your covered child, stepchild, or legal ward ceasing to qualify as an eligible dependent.

Important: To obtain the extension, you or your dependent must notify us within 60 days after the second qualifying event occurs, using the “Notice Procedures” described in the box above. Failure to timely notify us will result in your dependent losing the right to extend coverage.

Extension Due to Disability

You and your dependents may receive up to an additional 11 months of continuation coverage, for a total of up to 29 months from your initial qualifying event, if **both** of the following apply:

1. The Social Security Administration (SSA) determines you or your covered dependent to be totally disabled at any time during the first 60 days of continuation coverage. The SSA does not have to make its determination during the first 60 days. However, you or your dependent must be totally disabled, by SSA standards, at some point during those first 60 days, and the disability must last at least until the end of the 18-month period of continuation.
2. You notify us of the SSA determination of disability before the end of the original 18-month period of continuation coverage **and** within 60 days after the latest of these dates:
 - The date of the SSA determination of disability.
 - The date of the qualifying event (that is, the date of the termination of your employment or reduction in your work hours).
 - The date on which you lose coverage because of the qualifying event.

When you notify us, you must provide the name of the disabled qualified beneficiary, the date the qualified beneficiary became disabled, and the date the SSA made its determination. You must also provide a copy of the SSA’s determination. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if

any one of them qualifies. Failure to provide timely notice using the “Notice Procedures” earlier in this subsection will result in loss of the right to extend the period of coverage.

If the SSA later determines that the qualified beneficiary is no longer disabled, you must notify us of that fact within 30 days of the SSA’s determination. If that determination occurs during the 11-month extension period, continuation coverage will terminate, retroactively if applicable, for all qualified beneficiaries as of the first of the month following 30 days after the SSA’s determination. You will be required to repay all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled.

Extension Due to Your Medicare Entitlement

If you become entitled to Medicare benefits less than 18 months before you and your dependents lose coverage due to the termination of your employment or reduction in your work hours, federal law provides a special extension of continuation coverage for your dependents. In this instance, continuation coverage for your spouse and dependent children may last for up to 36 months from the date of your Medicare entitlement. This 36-month period is available only to your dependents, and only if you become entitled to Medicare within 18 months **before** the termination or reduction in hours. To obtain this extension, you or your dependent must notify us before the end of the initial 18-month continuation period.

How to Obtain Continuation Coverage

Within 14 days after we receive the required timely notice that a qualifying event has occurred, we will send a written offer of continuation coverage to each qualified beneficiary. We will mail this information to the most current address we have on file for you. Thus, to protect your rights, keep us informed of changes in your address. You should also keep a copy, for your records, of all notices you send to us.

Qualified beneficiaries will have a 60-day period, known as an election period, to elect to continue coverage under this policy or under our conversion policy. The election period will end 60 days after the later of these two dates:

- The date coverage ends as the result of the qualifying event.
- The date we send you information about your rights to continue coverage.

If you do not return your election notice indicating your choice to continue your coverage within that 60-day period, you will lose your right to elect continuation coverage.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, your spouse may elect continuation even if you do not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. You or your spouse, if your spouse is a qualified beneficiary, can elect continuation on behalf of all qualified beneficiaries.

Premiums for Continuation Coverage

Qualified beneficiaries are responsible for paying the premiums for continuation coverage. The premium rate will be the same as the rate in effect, on each date that premium is due, for the eligible class of employees to which you belonged while working. Premiums will change on the annual renewal date of the employer's group under which you are/were covered, or when the benefits of the employer's group plan are changed.

The initial premium payment for continuation coverage is due 45 days after the election is made. This payment must include premiums for all months from the time you lost coverage under the employer's group plan through the current month of coverage. Claims will not be processed and paid until we have received your first premium payment. Qualified beneficiaries who do not make their first payments in full within this time limit will lose their coverage continuation rights.

All subsequent premium payments are due on the 20th of the month that precedes the month of coverage. A grace period of 31 days applies. The grace period starts on the first day of the coverage month for which the premium is due. We will provide continuation coverage for each month as long as we receive the premium for that month before the end of the grace period. If you do not pay the premium within the grace period, continuation coverage, and your rights to continuation coverage, will terminate.

If you or your dependents timely elect continuation coverage and pay premiums, the period of continuation coverage will begin the day after the qualifying event. If two or more qualified beneficiaries elect COBRA coverage under a plan, we will apply the full family premium, rather than two or more single premiums.

When Continuation Coverage Ends

A qualified beneficiary's continuation coverage under this policy will end on the earliest of the following dates:

- The end of the period for which the last premium was paid in full and on time.
- The date on which the applicable 18-month, 29-month, or 36-month period of continuation coverage ends.
- During an 11-month disability extension period, the first of the month following 30 days after the SSA determines the disabled qualified beneficiary is no longer disabled.
- The date on which the qualified beneficiary becomes covered under another group plan that does not impose any exclusion or limitation for a pre-existing condition of the qualified beneficiary.
- For a qualified beneficiary who becomes entitled to Medicare benefits while on continuation coverage, the date that is 18 months after the date continuation coverage begins.

- The date on which we no longer insure the active employees in the occupational group within the eligible class of employees to which the covered employee belonged on the day before the qualifying event.
- The date on which the employer ceases to provide any group dental coverage for the eligible class of employees.
- The date this policy terminates for any reason.

You Must Notify Us if You Obtain Other Coverage

Qualified beneficiaries must notify us within 30 days if, after electing continuation coverage, they become covered under Medicare or under another group dental plan (but only after any exclusion or limitation of that plan for a pre-existing condition of the qualified beneficiary has been exhausted or satisfied). Continuation coverage will terminate, retroactively if applicable, as of the beginning of the other group coverage. Qualified beneficiaries will be required to repay all benefits paid after the termination date, regardless of whether or when they provided notice of other group coverage.

Coverage Continuation Option for Retired and Disabled Employees

If you retire at age 55 or older while you are covered by this policy as an active employee, you have the option of continuing coverage on the same terms as before your retirement. Similarly, if you become Disabled while covered under this policy as an active employee, your eligibility for coverage will not end solely because you are no longer actively working. Under these two circumstances, you may continue coverage as long as **all** of the following apply:

- We continue to insure the active employees in the occupational group within the eligible class of employees to which you belonged before you retired or became Disabled.
- Your employer permits all retired and Disabled employees from that eligible class to continue their participation in this policy.

- Your employer contributes premium for you at the same rate as for active, full-time employees in that eligible class.
- In the case of a Disabled employee, you remain Disabled.

The coverage and benefits you are eligible to continue will be the same as those that are in effect for the active employees in the occupational group within the eligible class of employees to which you belonged before you retired or became Disabled.

Example No. 1: You are a librarian covered under this policy at the time you retire at age 62. You decide to continue your coverage under this provision. Some time after you retire, the librarians that are actively working for your former employer move to a different Trust dental plan. Because your coverage and benefits are the same as those in the occupational class to which you belonged before retiring, you will also be moved to the new dental plan. You may, of course, decide that you no longer want to continue coverage and terminate your Trust dental plan.

Example No. 2: You are a teacher covered under this policy at the time you become Disabled at age 55, and you decide to continue your coverage under this provision. Later, the teachers that are actively working for your former employer move to a dental plan with a different insurer. Because we no longer insure the active employees in the occupational group to which you belonged at the time you became Disabled, you will lose your Trust coverage under this provision. Note that if you are still within the continuation period provided by state and federal law, you may be able to finish your period of continuation coverage under the employer's successor insurer.

This option is in addition to your rights to continuation coverage required by federal law. If and when you or your covered dependents are entitled to continuation coverage required

by law, that period of continuation coverage will run concurrently with the continued coverage provided for in this section.

If, while you enjoy the continued coverage provided for in this provision, you become eligible for Medicare Parts A and B, you should enroll for those benefits because we will coordinate the benefits of this policy with the benefits payable by Medicare, whether or not you enroll. See Section 9 for information about how we calculate benefits when this policy is secondary.

If you do not choose to continue coverage under this option at the time you retire, or become Disabled, you cannot do so later even during an open enrollment period. In that case, continued coverage for you and your covered dependents will be limited to that required by federal law.

If you continue coverage under this option, the following rules will apply to your dependents:

- If you marry, you may obtain coverage for any new eligible dependents and may change from single to family coverage. We will not require evidence of insurability for these new dependents if we receive the required enrollment form from you within 30 days of the date of your marriage.
- You may obtain coverage for eligible dependents during any group open enrollment that applies to the eligible class of employees to which you belonged while you were working.
- If you divorce, your former spouse will have the continuation rights required by federal law.
- Your dependent children are eligible for coverage as long as they qualify as dependents. When they no longer qualify, they will have the continuation rights required by federal law.

Extended Coverage for Certain Dental Expenses Incurred After Termination of Coverage

We will extend coverage for certain dental expenses incurred after termination of coverage under this policy if those expenses are for services that fulfill the requirements below.

Crowns, Onlays, Laminates, and Veneers

We will pay this policy's benefits for covered crowns, onlays, laminates, and veneers if **all** of the following apply:

- The teeth being restored were fully prepared to receive the crowns, onlays, laminates, or veneers before coverage ended.
- The necessary impressions of the teeth were taken before coverage ended.
- Any laboratory fabrication or other processing required to complete the crowns, onlays, laminates, or veneers was ordered before coverage ended.
- The crowns, onlays, laminates, or veneers were installed within 60 days after coverage ended.

Dentures

We will pay this policy's benefits for covered full or partial removable dentures if **all** of the following apply:

- The impressions used to prepare those dentures were taken before coverage ended.
- Any laboratory fabrication or other processing required to complete those dentures was ordered before coverage ended.
- The dentures were installed within 60 days after coverage ended.

Bridgework

We will pay this policy's benefits for covered fixed bridgework if **all** of the following apply:

- The teeth that serve as retainers or that support the bridgework were fully prepared to receive the bridgework, and the necessary impressions of those teeth were taken, before coverage ended.
- Any laboratory fabrication or other processing required to complete the bridgework was ordered before coverage ended.
- The bridgework was installed within 60 days after coverage ended.

Implant Services

We will also pay this policy's benefits for covered implant services if **all** of the following apply:

- The implant fixtures were placed and adequately integrated, and the necessary final impressions for restoration were taken, before coverage ended.
- Any laboratory fabrication or other processing required to complete the implant restoration was ordered before coverage ended.
- The implant restoration was installed within 60 days after coverage ended.

We will not cover services for replacement of a tooth that was extracted or accidentally lost after coverage ended, nor will we cover any service received after coverage ended except as described above.

Section 4

General Provisions That Apply to All Benefits

The subsection, “**Maximum Benefit Per Person Per Benefit Period**,” in Section 4 of the WEA Trust Dental Plan is replaced in its entirety with the following:

Maximum Benefit Per Person Per Benefit Period

This amount, which is specified on your Benefit Summary, is the total amount this policy will reimburse for each covered individual during the period of time identified on your Benefit Summary as the “Benefit Period.” Some Benefit Periods begin in September and run through August of the following year. Others may begin in January and run through December, or some other variation. We encourage you to check your Benefit Summary so you know when your Benefit Period begins and ends.

In calculating the Maximum Benefit Per Person Per Benefit Period, we will apply our reimbursements to the Benefit Period in which you incurred the charges for the covered services. Charges for services are considered incurred on the date the services are received except as follows:

- Charges for complete or partial dentures are considered incurred on the date the final impression is taken.
- Charges for fixed bridges, crowns, and onlays are considered incurred on the date the teeth are first prepared.
- Charges for root canal therapy are considered incurred on the date the pulp chamber is opened.
- Charges for orthodontics are considered incurred on the date the first appliance is installed.

The following paragraph is added as the last paragraph in Section 4 of the WEA Trust Dental Plan:

Noncompliance With Policy Requirements

Our waiver of any requirement of this policy will not constitute a continuing waiver of such requirement. Our failure to insist on compliance with any policy provision will not function as a waiver or amendment of that provision.

Section 7

Optional Benefits

Option 2 - Dentures, Bridgework, and Implants

The subsection, “*Services Not Covered*,” under Option 2 - Dentures, Bridgework, and Implants, in Section 7 of the WEA Trust Dental Plan is replaced in its entirety with the following:

Services Not Covered

We do not cover services other than those listed above. For example, we do not cover the following:

- Personalization of dentures or specialized techniques.
- Porcelain or similar facings, including the use of composite or bonding/veneer restorations, on molars.
- Precision attachments, semi-precision attachments, or other special constructions for dentures, bridgework, or any other dental appliance.
- Study models (diagnostic casts), photographs, or the duplication of X rays or models. (Study models and these types of diagnostic tools are not covered unless your Benefit Summary indicates you have coverage for Option 3, Orthodontics. If so, those services are subject to the applicable provisions in Section 7, Option 3, below.)

Option 3 - Orthodontics

The subsection, “*Reimbursement of Covered Orthodontic Services*,” under Option 3 - Orthodontics, in Section 7 of the WEA Trust Dental Plan is replaced in its entirety with the following:

Reimbursement of Covered Orthodontic Services

Reimbursement of covered orthodontic services is subject to a maximum amount for each covered dependent under age 19 during his or her lifetime. This amount is specified on your Benefit Summary as “Maximum Benefit Per Person Per Lifetime for Orthodontic Benefits.” We will pay the benefit amount in installments, subject to the applicable coinsurance and lifetime maximum, as follows:

- The first installment will be no more than one-third of the total charge for the entire course of orthodontic treatment. This installment is payable upon the initial placement of the appliance(s) or bands/brackets.
- The remaining two-thirds will be paid in installments over the remaining expected course of the orthodontic treatment plan.

We pay covered orthodontic services over the course of the treatment and not in one lump sum, even if you are required to do so.

Section 8

General Exclusions and Limitations

The following exclusion is added to Section 8 of the WEA Trust Dental Plan under #6.

6. We will not reimburse expenses for, or in connection with, any of the following:
 - Replacement of orthotics or prosthetics that have been lost, stolen, damaged, misplaced, missing, or otherwise compromised.

The “Domestic Partner Amendment,” is replaced in its entirety with the following:

Amendment

This amendment is applicable only if your Benefit Summary indicates “Domestic Partner.”

The Group Dental Policy is amended as follows:

Domestic Partner Amendment

Domestic partners and their children are eligible for coverage under this policy as dependents of covered employees. Domestic partners have the same rights, responsibilities, and entitlements as a legal spouse under this policy, with a few exceptions resulting from the different treatment of spouses and domestic partners under the law. Those exceptions are described below. If we approve a domestic partner’s enrollment, his or her biological or legally adopted children who meet the policy’s requirements for eligibility have the same rights, responsibilities, and entitlements as an employee’s stepchildren under this policy. These covered dependents, the employee, and the employee’s other covered dependents, if any, comprise a family as that term is used in this policy.

Definition of Domestic Partner

We define a domestic partner as an individual with whom you have agreed to live as sole domestic partners in a relationship that is characterized by *all* of the following:

- You have a committed spousal-type relationship of mutual support and caring, and you intend to remain in the relationship indefinitely.
- Your domestic partnership is and has been for the past six months publicly

acknowledged and commonly recognized within the communities in which you live and work.

- You share financial resources and have agreed to be responsible for each other’s common welfare.

Qualifying for Eligibility as a Domestic Partner

To establish that the individual qualifies for eligibility as a domestic partner, both of you must attest to all of the following on our Designation of Domestic Partner form:

1. You are both 18 years of age or older.
2. You are both mentally competent to make the declarations required by the form.
3. You are not related by blood closer than would bar marriage in the state of Wisconsin.
4. For at least the past six months, all of the following have been true:
 - You have lived together in the same dwelling unit.
 - Neither of you was married or legally separated in marriage.
 - Neither of you was a party to an action or proceeding for divorce or annulment.

- Neither of you was in another domestic relationship.
- You were financially interdependent as evidenced by at least two of the following:
 - (1) Common or joint ownership of a residence.
 - (2) Joint ownership of a motor vehicle.
 - (3) Joint credit account; for example, a credit card.
 - (4) Joint checking or savings account.
 - (5) Your domestic partner identified as primary beneficiary in your will, life insurance policy(ies), tax-sheltered annuity account(s), IRA(s), or other retirement accounts.
 - (6) Joint financial investments.
 - (7) Other evidence of mutual financial interdependency that we deem acceptable.

The signed Designation of Domestic Partner form is part of the contract of insurance, and we reserve the right to verify the information at any time.

When Your Domestic Partner Is Eligible for Coverage

Your domestic partner is eligible for coverage on the later of these two dates:

- The date you are eligible for coverage.
- The earliest date on which your domestic partnership fulfilled **all** of the conditions we have described above.

How to Obtain Coverage

Your domestic partner's coverage will begin on the date he or she is eligible if **both** of the following apply:

- We have received the required documents within 30 days of that date.

- We approve the enrollment based on the information submitted.

The required documents are these:

1. An enrollment form listing all individuals for whom you wish coverage.
2. The signed Designation of Domestic Partner form.

If we do not receive the required documents within 30 days of initial eligibility, the policy's procedures and rules for late enrollment, described in Section 3, apply.

Policy Provision Exceptions That Apply to Domestic Partners

Policy provisions that pertain to an employee's covered spouse apply to your covered domestic partner. Exceptions are these:

1. Domestic partners are not entitled by state and federal law to continuation of coverage when their coverage ends due to certain qualifying events. However, this policy provides continuation privileges to covered domestic partners and their covered biological or legally adopted children under circumstances, and for temporary periods, that are similar to those required by law for qualified beneficiaries.

Please note that we require you or your domestic partner to notify us in writing within 60 days of the date of the termination of the domestic partnership in order to preserve these dependents' rights to continuation coverage. If we don't receive the written notice within the time period specified, continuation of coverage under this policy will not be offered.

2. This policy will pay as secondary insurer to Medicare for a covered domestic partner who is 65 or older because of the federal rules that regulate coordination with Medicare benefits.

Eligibility of Your Domestic Partner's Children

Biological or legally adopted children of your covered domestic partner are eligible for coverage as dependents on the same date as the domestic partner is eligible. Coverage for these children will begin on the date they are eligible if **both** of the following apply:

- We have received your application for their coverage within 30 days after they first became eligible.
- We have approved coverage for your domestic partner.

Policy provisions that pertain to the stepchildren of an employee apply to your domestic partner's children. Therefore, they are eligible for coverage only as long as your domestic partner remains eligible.

Except as expressly stated above, this amendment does not waive, alter, or extend any of the provisions or exclusions and limitations of the policy.

Amendment Effective Date – The effective date of this amendment is coincident with the Effective Date stated on the Benefit Summary.

When the Domestic Partnership Ends

For purposes of this insurance, the domestic partnership ends on the earlier of these dates:

- The date your domestic partnership ceases to fulfill one or more of the criteria on the Designation of Domestic Partner form.
- The death of one of the two individuals in the domestic partnership.

The end of a domestic partnership has the same consequences under this policy as divorce or annulment of marriage. Therefore, the domestic partner and his or her children are no longer eligible for coverage as of the date the domestic partnership ends, except as described above.

The “Waiver of Premium” Amendment is replaced in its entirety with the following:

Amendment

This amendment is applicable only if your Benefit Summary indicates “Waiver of Premium.”

The Group Dental Policy is amended as follows:

Waiver of Premium

After a covered employee is Disabled for more than 60 continuous calendar days, the monthly premium required for coverage of the covered employee and his or her covered dependent(s) will be waived. We will waive the premium ***beginning on the first day of the month following 60 consecutive days of Disability*** until the earliest of the following dates:

- The date the covered employee ceases to be Disabled as determined by us.
- The date the covered employee becomes eligible for Medicare benefits.
- The date the covered employee dies.
- The date the covered employee fails to furnish proof satisfactory to us of continued Disability.
- The date this policy terminates for any reason.
- The date the covered employee ceases to be eligible for coverage under the terms of this policy.

Premium will be waived for a maximum of 30 months for any one Period of Disability.

Premium payments must be resumed beginning with the month in which the covered employee resumes his or her regular job duties as a member of the eligible class of employees specified by the employer.

Period of Disability means one continuous period of Disability beginning on the covered employee’s date of Disability as determined by us and ending on the date on which the covered employee dies or ceases to be Disabled. Successive periods of Disability will be deemed to be the same Period of Disability unless:

- Due to an unrelated cause and separated by a return to the regular performance of job duties for the employer, ***or***
- Due to the same or related cause, but separated by a return to the regular performance of job duties for the employer for six consecutive months.

The 60-day qualifying period referred to above must be satisfied only once for a Period of Disability. If a Disabled employee endeavors to resume work for the employer during a Period of Disability, the 30-month maximum period of premium waiver will be extended. It will be extended by the number of days on which the covered employee works and for which resumed premium payments are made.

Waiver of premium applies only to a covered employee who becomes Disabled ***after*** the effective date of this optional benefit.

To qualify for the waiver of premium, the employee must be under the regular care of a

Physician. This means that ***all*** of the following apply:

- The employee is being seen by a Physician at intervals of time appropriate for treating the disabling impairment(s).
- The Physician is rendering and/or prescribing a pertinent treatment plan or a practical protocol, if one exists, for alleviating or eliminating the impairment(s) causing the Disability.
- The employee is complying with all aspects of the Physician-prescribed treatment plan.

Waiver of premium applies only to the type of coverage (single or family) in effect for the covered employee on the date of Disability.

Waiver of premium does not apply to a covered employee who was not Disabled at the time of his or her retirement and who is covered under the “Coverage Continuation Option for Retired and Disabled Employees” described in Section 3 of the policy or the “Coverage Continuation Option for Retired and Disabled Employees” amendment.

Except as expressly stated above, this amendment does not waive, alter, or extend any of the provisions or exclusions and limitations of the policy.

Amendment Effective Date – The effective date of this amendment is coincident with the Effective Date stated on the Benefit Summary.

The “Coverage Continuation Option for Retired Employees” amendment is hereby replaced in its entirety with the following:

Amendment

This amendment is applicable only if your Benefit Summary indicates “Coverage Continuation Option for Retired and Disabled Employees.”

The Group Dental Policy is amended as follows:

The subsection entitled “***Coverage Continuation Option for Retired and Disabled Employees***” in Section 3 is replaced with the following:

Coverage Continuation Option for Retired and Disabled Employees

If you retire at age 55 or older while you are covered by this policy as an active employee, you have the option of continuing your coverage under this policy. Similarly, if you become Disabled while covered under this policy as an active employee, your eligibility for coverage will not end solely because you are no longer actively working. Under these two circumstances, you may continue coverage as long as ***all*** of the following apply:

- We continue to insure the active employees in the occupational group within the eligible class of employees to which you belonged before you retired or became Disabled.
- Your employer permits all retired and Disabled employees from that eligible class to continue their participation in this policy.
- We receive the required premiums on time.
- In the case of a Disabled employee, you remain Disabled.

The coverage and benefits you are eligible to continue will be the same as those that are in effect for the active employees in the occupational group within the eligible class of employees to which you belonged before you retired or became Disabled.

Example No. 1: You are a librarian covered under this policy at the time you retire at age 62. You decide to continue your coverage under this provision. Some time after you retire, the librarians that are actively working for your former employer move to a different Trust dental plan. Because your coverage and benefits are the same as those in the occupational class to which you belonged before retiring, you will also be moved to the new dental plan. You may, of course, decide that you no longer want to continue coverage, and terminate your Trust dental plan.

Example No. 2: You are a teacher covered under this policy at the time you become Disabled at age 55, and you decide to continue your coverage under this provision. Later, the teachers that are actively working for your former employer move to a dental plan with a different insurer. Because we no longer insure the active employees in the occupational group to which you belonged at the time you became Disabled, you will lose your Trust coverage under this provision. Note that if you are still within the continuation period provided by state and federal law, you may be able to finish your period of continuation coverage under the employer’s successor insurer.

This option is in addition to your rights to continuation coverage required by federal law. If and when you or your covered dependents are entitled to continuation coverage required by law, that period of continuation coverage will run concurrently with the continued coverage provided for in this amendment.

If you do not choose to continue coverage under this option at the time you retire or become Disabled, you cannot do so later even during an open enrollment period. In that case, continued coverage for you and your covered dependents will be limited to that required by federal law and described in Section 3 under “Your Legal Rights to Continuation Coverage.”

If you continue coverage under this option, you will be responsible for paying the required premiums for coverage. Your premium will be based on the group rates in effect for your former employer on each date that premium is due. Your premium will depend on the rate classification to which you belong. You may find the rate classifications and corresponding premium amounts on the employer’s Rate Summary.

If, while you enjoy the continued coverage provided for in this provision, you become eligible for Medicare Parts A and B, you should enroll for those benefits because we will coordinate the benefits of this policy with the benefits payable by Medicare, whether or not

you enroll. See Section 9 for information about how we calculate benefits when this policy is secondary.

If you exercise this option, the following rules will apply to your dependents:

1. If you marry, you may obtain coverage for any new eligible dependents and may change from single to family coverage, but only if we receive the required enrollment form within 30 days of the date of your marriage. If we do not receive the enrollment form within 30 days of your marriage, you cannot enroll the new dependents later, even by presenting evidence of their insurability. In other words, this policy’s provisions under “Late Enrollment Procedures and Rules” in Section 3 do not apply in this case.
2. You may obtain coverage for eligible dependents during any group open enrollment that applies to the eligible class of employees to which you belonged while you were working.
3. If you divorce, your former spouse will have the continuation coverage rights required by federal law.
4. Your dependent children are eligible for coverage as long as they qualify as dependents. When they no longer qualify, they will have the continuation coverage rights required by federal law.

Except as expressly stated above, this amendment does not waive, alter, or extend any of the provisions or exclusions and limitations of the policy.

Amendment Effective Date – The effective date of this amendment is coincident with the Effective Date stated on the Benefit Summary.

